for the family physician

CLINICAL MEDICINE

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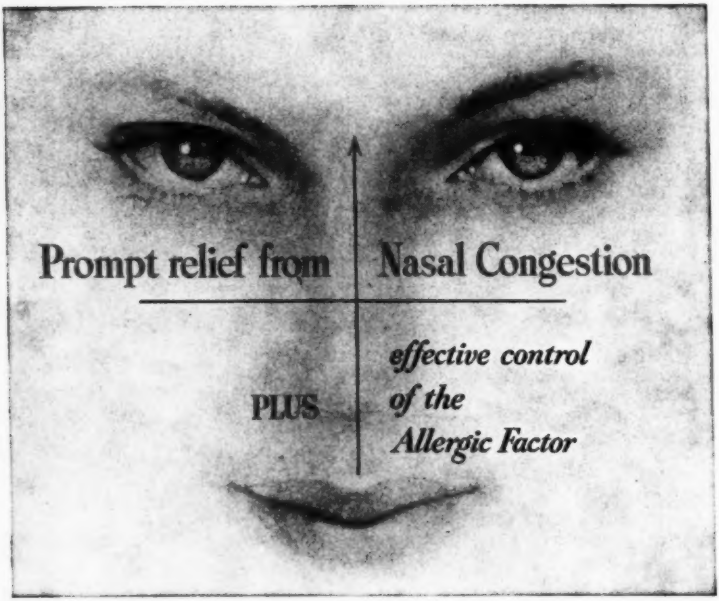
Editorial

Original Articles



"Allergy is perhaps the commonest cause of a stuffy nose . . .", according to Dill.[1] Shambaugh[2] states that ". . . 70% of all chronic suppurative sinusitis is on an allergic basis." He emphasizes the importance of controlling the allergic factor in nasal congestion.

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1. Postgrad. Med. 4:413, 1948. • 2. M. Rec. & Ann. 42:673, 1948. • 3. Am. Pract. 2:643, 1948.

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for the family physician

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EDITORIAL

"DIANETICS"

by FREDERIC R. STEARNS, *Editor*

If the present signs are not deceiving we are up against a new system of quackery of apparently considerable dimensions. L. Ron Hubbard has published a book: "Dianetics," The Modern Science of Mental Health (New York, Hermitage House, 1950) the release of which he has accompanied by an article in the "Astounding Science Fiction" magazine. Hubbard, indeed, claims to have found a panacea for all mental illness. On the first page of his book he states with the usual modesty of all pretenders of final medical wisdom that "the hidden source of all psychosomatic ills and human aberration has been discovered and skills have been developed for their invariable cure." It is in keeping with this assertion that Hubbard describes dianetics as an exact science. He differentiates between an analytical mind, a merely mechanical device, which cannot err if supplied with the correct data, and a reactive mind which is the source of deviating forces and which puts the mechanical mind out of order so that it produces morbid responses. Hubbard ceates the concept of the "Engram Bank" which means memory traces imprinted into the cell structure. These engrams are essentially the cause of all mental disturbances as they are characteristic of the reactive mind and as they are responsible for the wrong data fed to the analytical mind. The therapeutical method of dianetics consists of tracing the devilish circuits of the engrams and of invalidating them by reproduction and ventilation. This technique, within a relatively short time and with absolute certainty, accomplishes the "clearing" of the mind, and the mental patient is cured.

Any reader will see that Hubbard's "Dianetics" is nothing but a rumination of old psychological concepts, popularized and oversimplified, therefore, misunderstood and misinterpreted and at the same time adorned with the halo of the philosopher's stone and of an universal remedy.

No wonder that "the mathematician and theoretical philosopher" Hubbard has gathered around him already a multitude of active and passive followers. His averment that the technique of dianetic therapy is simple and can be applied to each other by any two reasonably intelligent people after a brief study of his book, has of course yielded a big crop of dianetic healers, credulous or otherwise, and the harvest in monetary and sectarian returns is already in proportion with the amount of unimproved assertions and uncritical pledges, as brought forth in this "Modern Science of Mental Health."

The danger of these pseudo-scientific movements and their unchecked promotion of "treatment" of sick people is obvious. Some so-called testimonials, as they are presented by dianetic healers, are obtained by all "healers," as a temporary improvement of symptoms by suggestion; this is as old as Methuselah. It always has been the trick of all omniscient medical outsiders to minimize the steady labor of scientific, particularly medical, research and to come to the fore with solutions of Aladdin's magic lamp. They are fairy tales, of course, but perilous ones as they gamble with human health. The patient pays the price.

ORIGINAL ARTICLES

Anesthesia for the General Practitioner

by SEYMOUR BROWN, M.D.*

Despite the fact that the field of anesthesiology is becoming increasingly more specialized and limited to medical men with specific training, one should recognize that the general practitioner still bears the responsibility for this phase of medical practice in a large segment of rural and some urban communities. Opportunities are broadening for the general practitioner to procure short postgraduate courses in various aspects of anesthesia at numerous university medical centers throughout the country, and he should make an effort to familiarize himself with this specialty.

In the hospitals where no anesthesiologists are available the surgeon and/or the general practitioner usually orders the premedicative drugs. In many institutions this procedure becomes entirely routine with certain standing orders for surgical cases from each doctor. Such a practice is to be condemned. The individual appraisal of each patient as regards the age, physical status, and contemplated anesthetic and technique of anesthesia is extremely important.

The desired effects of premedication are optimum psychic depression, heightening of the pain threshold, reduction of reflex irritability and metabolism, and antagonism of undesirable side effects of the anesthetic agents. Premedication for procedures under regional anesthesia should be more profound than for those performed under general inhalational or intravenous anesthesias in which heavy sedation may delay induction or cause excessive depression during the anesthesia. Opiates decrease susceptibility to pain and reduce reflex irritability and metabolism but provide poor hypnosis and very little protection for the undesirable side effects of anesthetic agents. Barbiturates produce hypnosis, antagonism of undesirable side effects of anesthetic agents, and some depression of metabolism. The belladonna drugs in optimum dosage depress mucus secretions, antagonize respiratory depressive effects of opiates, provide amnesia, and have a definite vagolytic action as regards reflexes. The aged and the very young are especially susceptible to the depressive respiratory effects of opiates, and for this reason these should be administered in commensurately small doses. The debilitated and anemic patients are depressed unduly by the barbiturates and opiates. Thus careful consideration of the dosage of the preanesthetic drugs in relation to the age, physical status of the patient, and procedure contemplated facilitates the induction and conduct of the anesthesia and helps insure the safety of the surgical procedures.

The inhalational anesthetics may be divided into the volatile and gaseous agents. Volatile agents include ethyl ether, vinyl ether (vinethene) ethyl chloride, and chloroform. Gaseous agents comprise nitrous oxide, ethylene, and cyclopropane.

Ethyl ether is one of our oldest and most frequently employed anesthetic drugs and in the comprehensive picture is probably our saf-

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est agent. It is capable of producing complete muscular relaxations without impairing oxygenation, and it has a wide margin of safety in relation to the optimum and toxic concentrations. However, its administration is unpleasant, and the frequent postoperative effects of prolonged recovery time, distention, nausea, and emesis make it unpleasant to the patient. Furthermore, the characteristic of ethyl ether to produce insulin depression, acidosis, and glycogenolysis makes it undesireable for administration to diabetic patients. However, despite the advent of many more pleasant and potent agents with a small margin of safety, ethyl ether remains one of the bulwarks of the anesthetist when difficulties arise.

Vinyl ether, like ethyl ether, has an unpleasant odor but has a good margin of safety. It is relatively unstable when once exposed to air and has a deleterious effect on the liver if given for long periods, especially if insufficient oxygen is present. However, it is fine for short anesthetics in minor procedures, giving a quick induction and fast recovery usually without emesis.

Chloroform has a slightly pungent odor and is not inflammable as are the aforementioned drugs, but it has a small margin of safety as regards the toxic concentration. Its numerous deleterious side effects, such as depression of cardiac output and peripheral circulation, increase in cardiac irritability, and production of liver damage, have decreased its use tremendously in this country.

Ethyl chloride has a slightly irritating odor but is a potent agent giving a quick induction and recovery. It has a small margin of safety and not infrequently causes respiratory arrest. Its ease of transport in conveninet vials made it popular for use in minor procedures before the advent of intravenous anesthetics or vinyl ether.

Among the gaseous agents nitrous oxide has practically no odor and is not inflammable or explosive, although it will support combustion. It can produce first plane of surgical anesthesia without hypoxia, but muscular relaxation is minimal. Thus, the use of this agent requires a greater amount of premedication and supplementation with other anesthetic drugs. It should not be used in concentrations higher than 75-80% and is most useful in long procedures requiring no muscular relaxation, such as skin grafts, neck, and oral surgery with the endotracheal technique and pentothal sodium.

Ethylene has a disagreeable garlic odor and is approximately 15% more potent than nitrous oxide. It is inflammable and tends to cause nausea and emesis in the patient. It is capable of producing a mild degree of muscular relaxation when used in a concentration comparable to that of nitrous oxide.

Cyclopropane is a potent gas with capabilities of complete muscular relaxation without hypoxia. Its margin of safety is less than that of ethyl ether but greater than ethyl chloride. It is inflammable and explosive. In contrast to ethyl ether it is definitely parasympathomimetic in its actions.

Of the intravenous agents in use pentothal sodium is now enjoying the greatest popularity. New drugs such as surital sodium, intravenous salts of seconal and nembutal, and spirothio-barbituric acids are being tried, but final evaluation of these will be possible only after extensive trials. Pentothal sodium is best administered in 2.0-2.5% concentrations intravenously but may be used in 0.2-1.0% concentrations for sedation or for anesthesia in the very young or in the aged patients. It is a potent hypnotic but has little definite analgesic properties. It produces a very rapid and pleasant induction with no unpleasant side effects on emergence from anesthesia. However, recovery time is directly proportional

to the length of the hypnosis and thus when used as the sole agent the effect is cumulative and may produce prolonged sleep with respiratory depression. It is an excellent agent for minor procedures, as an inductive agent in inhalational anesthesias, or as a supplement to other agents in inhalational or regional techniques of anesthesia. It is a definite parasympathomimetic drug and thus the laryngeal reflex is frequently quite active. It should not be used in any condition in which control of the airway is not assured throughout the procedure and for a period postoperatively. Thus its use is contraindicated in patients in prone position or in oral or neck surgery unless endotracheal intubation is performed. In this regard it should be emphasized that approximately 90% of the deaths in patients occurring under anesthesia are due to obstruction of the airway. This may occur anywhere from the lips to the alveoli, but the most frequent site is the oropharynx. The usual cause is relaxation of the jaw with the tongue either falling back passively or being pushed pack by pressure on the mandible from an anesthetic mask.

In the field of regional anesthesia there are the divisions of spinal intrathecal blocks with various refinements of limited areas of involvement, fractional, and fractional segmental administrations. Another method of spinal block avoiding the puncture of the dura with its possible complications, is epidural block of limited or extensive involvement. Various types of nerve blocks can be produced such as cervical plexus, brachial plexus, elbow, wrist, and finger anesthesias. Areas may be directly infiltrated or surrounded by a wall of anesthetic agent in the skin some distance from the site of operation so as not to distort the field. Certain drugs such as cocaine, pontocaine, nupercaine, or butyn may be used to produce topical anesthesia on mucosal surfaces. The application of such techniques requires knowledge of the anatomy involved and thus cognizance of the dangers of injudicious punctures with a needle. It also requires cooperation of the patient to undergo the procedure and an awareness of the anesthetist of the toxicity of the solution used. Such procedures necessitate the availability of oxygen for use in respiratory depression or in air hunger secondary to severe hypotension which may occur as a toxic reaction of the patient. Vasoconstrictor drugs should likewise be easily procureable. If the patient shows signs of neuromuscular irritability or convulsions, oxygen administration and an intravenous barbiturate for sedation are mandatory.

The past few years have seen the development of numerous curariform drugs as an adjuvant to general anesthesia to produce optimum muscular relaxation in a lighter plane of anesthesia. These drugs are serving a useful purpose in this regard but have been sadly misused in a number of instances in which excessive amounts have been administered in the attempt to procure relaxation without proper anesthesia. Such circumstances produce complete respiratory paralysis which is not efficiently antagonized by any drug at present and which, because of concomitant changes in blood pressure and oxygenation, have resulted in numerous serious complications and in some cases death. Thus it is urgently advised that these drugs which have no analgesic properties in clinical use by administered only by trained personnel with the ability to do endotracheal intubation and efficient artificial respiration.

In conclusion it is urged that a real working knowledge of anesthesia requires a large amount of assiduous reading on the subject, together with carefully supervised practical experience. Men who are responsible for this important phase of medical practice should make a sincere effort to familiarize themselves thoroughly.

ORIGINAL ARTICLES

The Insurance Medical Examination

by ELLIS M. MARKELL, M.D.

Medical Referee, Companion Life Insurance Company and Mutual Benefit Health & Accident Association

Physicians by and large have come to realize that insurance examining can add substantially to their practices and also serve as a mode of introduction to new families in their communities. Too few examiners, however, are aware of the actual significance of their reports. This article is an attempt to throw some light into the abyss wherein the completed examination form disappears.

OCCUPATION — Risky jobs obviously place an applicant in a special category. But bartenders and even operators of package liquor stores are found to have an increased mortality rate. Likewise, a person employed in a bad neighborhood may fall into a special category. Thus, occupation enters into both moral and physical evaluation.

RECENT EXAMINATIONS — A person who has had several recent examinations is showing an interest in insurance coverage which may have unholy motivation.

PREVIOUS REJECTIONS—I wish I could tell you what percentage of insurance rejectees later deny it on subsequent exams. Unfortunately, I don't know, but it would seem to be a big figure! Frequently during the examination I repeat this question. If the examiner gets in the habit of asking questions before he sees the applicant, finding out from the person who orders the examination anything he can about past history, draft status, etc., it gives him an island of information from which he can reach out.

FAMILY HISTORY — It is unlikely that any physician needs instruction in the value of this line of questioning. However, insurance medicine is just a bit more specific in its evaluation here. In some underwriting offices it is customary to use a numerical system. An applicant with a mild cardiac condition is, under such a system, given a less severe rate-up if his family history is clear, than if a parent has or had a circulatory disease. Likewise, a debit of perhaps —10 is given for two members of the family with circulatory histories even where the applicant has no abnormality. Longevity of parents and siblings is a good lead to an individual's expectancy. This rule is rife with exceptions, but it is nevertheless a good enough generalization to warrant the man with the blue pencil putting a plus or minus mark in the margin as he rates the examination paper.

PAST MEDICAL CARE—Strangely enough, this information, which is just about the most important part of the entire examination, is frequently not appreciated. True it is that applicant does not know within a year when he was treated in the past, but the extreme vagueness of the examiner's answers to these questions decreases with his insurance experience. Nor is "Dr. Katz, New York City" enough to identify the attending physician. Keep in mind that this information is actually used and the Medical Referee or Underwriter who uses it may be the one who can determine whether you get few or many examinations to do.

Nature of illness is likewise vitally important. "Simple cold" does not put a man to bed for a week. I cannot emphasize enough the importance of these details. Some companies check all recent care, while others depend on your description of the illness to determine which

cases should be investigated. A most important "acute nothing" is the statement made by about 30% of all applicants that they went to the doctor for a check-up. We find that the actual figure is nearer 3%, the rest having sought medical care for illness. These cases are often investigated and the facts brought out are frequently sufficient to make the examiner look sick were he to know of them.

PAST HISTORY—Practically all insurance blanks call for specific questioning in regards to past illnesses and symptoms. Ask an applicant if he has ever been ill and he will usually say no. Then come the specific questions and it turns out that, while never ill, he has been hospitalized, operated upon, and has had two E.K.G.'s. Yes, asking all the specific questions takes time, but it pays off.

SIGNATURE—Customarily both the applicant and the medical witness now sign the completed face of the blank. If one or both signatures are in Chinese, and the name is not printed out elsewhere, the resulting situation can be interesting though confusing.

Up to now, we have talked of the front of the medical blank. This is the part which is photostated and becomes a part of the application, binding the applicant to the statements he has made, at least for the first two years of the contract. Death claims can be contested on the basis of fraudulent answers during that time and you may be called to court to face your handiwork—blots and all. No additions or reservations on the reverse side show up as part of the actual insuring contract but a continuation sheet attached to the face of the blank does.

PHYSICAL EXAMINATION—Some very interesting books,[1 2] have been written on this subject, but there are a few spots I wish to touch upon because they are subject to frequent misinterpretation.

Deformity or Impairment of Senses: There is a point in loss of visual or auditory acuity where the victim is no longer a standard risk. It does not suffice for the examiner to know that the impairment is slight,—the underwriter must be told. It is vitally important that you indicate the degree of impairment and correction. This same principle goes for any deformity. Kyphosis is important to note but that isn't enough. How much of a "kink" is there and is it due to Pott's Disease, fracture, Ricketts or Cancer? You're right—you can't tell, but maybe the applicant knows, and if not he can give you a history of his Kyphosis which will help. And perhaps there are associated findings.

Pupillary Reactions: It may surprise you to know that I have seen three rejections for Argyll-Robinson pupils in two years. Strangely enough, all three were typical middle-class men or women. Doctor have you checked the pupils of every applicant?

Height and Weight: Here's the big bugaboo. In Dr. Harry Digman's delightful text-book "Risk Appraisal."[1] he devotes fifteen pages to this subject, plus two oversize charts as an appendix. It is one of the chief points in your examination. The measurements that accompany the weight have two functions. First they tell about build (is the abdomen thicker than the expanded chest?, etc.) and secondly, to the trained eye of the Home Office Physician or Underwriter, who reviews the paper, they tell whether the weight is correct. From the measurements, it is easy to tell quite accurately what your applicant weighs. The charts are somewhat off on the out-sizes, and also, where there has been a bout of reducing, measurements remain high for some time after weight has dropped, but it is still a fairly accurate estimation. When you don't have a portable scale for home examinations, and where an off-size

applicant denies having one in the bathroom, take him to the corner drug-store and get him weighed there.

Blood Pressure: Most carriers accept 140/90 and a pulse pressure of fifty as about top normal. Usually this feature of the examination is well handled, but remember please that a pressure of 142/92 may make the risk substandard, so be sure of yourself when you record borderline figures. On the other hand, some companies keep a record on the examiner's card of his blood pressure readings and too many 140/90's will lead to a definite suspicion. Don't be afraid to take a number of readings but record them all, and indicate the time interval.

Heart: The interpretation of murmurs is subject to such great variation that many underwriting offices simply classify them as "systolic without hypertrophy," "systolic with hypertrophy," etc. Functional murmurs are frequently, for insurance purposes, considered as nonexistent after age thirty-five. But even in young people it has been clearly shown statistically that the percentage of people who will have subsequent heart disease is greater in those with murmurs designated and accepted as functional than in those without tonal aberrations. Some of the increase is undoubtedly due to misinterpretation, but we cannot be sure as yet that this tells the whole story.

Abdominal Examination: This is frequently difficult to do since so many insurance examinations are done at applicant's place of business; nevertheless, it's obviously important. Herniae do not enter seriously into life expectancy, but it always makes the examiner feel silly to get a letter from Home Office stating that applicant has a Medical Information Bureau history of two to six herniorrhophies and what is his condition now? The same sort of thing happens with an enlarged liver or any other abdominal mass or scar.

Examiner's Opinion: Many medical blanks call for your decision as to insurability. If you are an experienced examiner, you are able to weigh the abnormalities found. If uncertain, put something like "subject to Blood Pressure," or "subject to further investigation of recent surgery." Too often I have seen the examiner call the risk a good one where it was definitely substandard and sometimes uninsurable on the basis of this very examination. Weight and Blood Pressure are the usual things such an opinion slights.

This just about sums up what I had in mind, but to illustrate a few points, let me cite a recent examination. Generally speaking my examinations are only of cases known to be or suspected to be substandard risks, although I do get an occasional normal in a "jumbo" application (over $25,000). In this particular case I was told in advance that there was a history of mental illness. Applicant did not mention it at all until I refused to accept his answer about not having been hospitalized at any time, asking specifically "weren't you in a mental hospital in 1945 for some time?" Now remember, I did not know he had been hospitalized but simply that he had had some mental disturbance. He then owned up to one admission of the two I later found out about by sending his signed authorization to a State Institution. Next, I examined him. He really was in excellent general condition but even a very thin

undershirt can hide things so he was told to remove it, thereby revealing two fresh upper abdominal scars. This was news to me but I snapped my fingers and exclaimed that I had completely forgotten about his recent surgical history. After that it was easy to get a true story and to call his surgeon for confirmation of his findings. Thus, an applicant who could easily pass a careless examination was found to be first, substandard on the basis of recent cholecystectomy followed by drainage of an abscess of the liver, and then entirely uninsurable due to Dementia Praecox.

I frequently review the papers of an examiner who obviously does not appreciate the significance of his own findings. However, his handwriting is delightfully clear and his examination is genuinely complete, and I love him! His opinions on insurability are frequently the only source of humor I meet in a busy day but I still try to get all the work I can to him. Do you write legibly?

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Treatment of Ocular Injuries In Industry and Private Practice

by F. A. WIER, M.D., *Racine, Wisconsin*

Mary, aged 6, tried to untie the knot in her shoe lace with an ice pick, the pick slipped and struck her in the left eye and penetrated the globe and lacerated the iris just below the pupil and made a permanent iredectomy which doesn't show unless the lower lid is pulled down.

Treatment—Eserine salicylate 1% sol. to contract the pupil and prevent further tearing, mercurochrome 2% sol. for the antiseptic effect and tight bandage thoroughly strapped with adhesive tape to prevent the patient from getting her fingers under it and doing any further damage. The bandage was left on for three days and when removed the eye was apparently well. However, the bandage was kept on for a few days longer to prevent her from rubbing the eye. Patients often do more harm than the original injury by violently rubbing the eye.

Mr. D—A carpenter was repairing a ceiling in a factory. A piece of wood fell down and struck him in the left eye, lacerating the cornea and tearing out one third of the iris on the nasal side. I had little hope of saving the eye, but knowing the uncanny tendencies of some badly mutilated eyes have to get well, we always give an eye another chance, so I took two deep stitches above and below in the conjunctiva and pulled them tight, bringing the edges of the cornea in close juxtaposition, flushed the eye with mercurochrome 2% sol., applied a tight well taped bandage, and left it on for three days. If a corneal laceration is not infected, it will be sealed tight in three days. My theory is that the gush of aquaous fluid from the Anterior Chamber following a laceration flushes the wound and cleanses the edges of any infectious material.

And also that mercurochrome is the best antiseptic for a lacerated cornea. Well, on the third day, I gently separated the lids. And on inspection. I was delighted to see that the corneal wound was sealed. From then on the eye made an uneventful recovery, and the patient could count fingers on the temporal side at three feet. Vision enough to walk around, if he should be so unfortunate as to lose the right eye, as it was he was able to resume his trade as a carpenter.

Mr. B—Got mixed up in a tavern brawl. He wore glasses and a sailor struck him in the right eye, broke his glasses and caused a laceration of the cornea from the nasal side to the temporal side of the corneoscleral junction. A clear cut incision. Finger tention seemed below normal, but this was due no doubt to the evacuation of the aquaous, the iris was intact so all I had to fear was infection, as if that wasn't enough. The treatment was much the same as the previous case. Two deep stiches were placed above and below the laceration on the nasal side and temporal side, in the conjunctiva and the edges of the cornea pulled tight together. Atropine 1% sol. was instilled to dilate the pupil and prevent adhesions between the iris and the cornea. Ten minutes later mercurochrome 2% sol. was instilled for its antiseptic effect, and a tight bandage was applied and left on for three days. On its removal, the eye looked good and there was only a mild conjunctivitis and scleritis, atropine and mercurochrome were again instilled and the bandage reapplied for three days more. On removal, the eye looked good. The corneal wound had healed. The stitches were removed, mercurochrome was instilled and the bandage reapplied for three days more, mostly to keep the patient from rubbing his eye. No matter how seriously an eye is injured, the patient will rub it violently, if he gets a chance. Well, this case made a perfect recovery except for a scar across the cornea which made central vision a little difficult.

Mr. J—While chipping steel was struck in the left eye by a chip of steel which penetrated the eyeball about 5mm below the corneo-scleral junction on the temporal side, and passed straight across the eye, missing the lens and pentrating the retina on the nasal side, also, cutting a blood vessel in the retina which produced a profuse hemorrhage, which caused instant blindness. He reported to the nurse in the factory. She looked at his eye and told him that she couldn't see any foreign body and to forget it, and it would be all right. Well, this young man was too smart to heed such advice, so he left his work and consulted me at once. Examination showed the interior of the eye all black and no eye grounds were visible. An X-Ray was made at once and showed the chip of steel very plainly embedded in the nasal side of the retina. It was easily removed with a giant magnet. The blood soon absorbed and vision returned to 20/20, his normal vision.

Mr. B—Filing piano plates. The handle and the file came apart and the butt end of the file struck him in the right eye, causing a ragged tearing separation of the conjunctiva, sclera, cornea and lower edge of the iris, and a hemorrhage in the globe. The upper and lower edges of

the wound looked like saw teeth. Well what to do!

It looked like a hopeless case. The only favorable feature was that the tention was fairly good indicating that there had been no loss of vitreous. I asked the patient if he had rubbed his eye at the time of the accident. He said no, it didn't hurt and he worked one half hour afterward. His foreman found out about it and rushed him to my office. Well, something had to be done, so I went to work with a blunt spud and a small pair of toothless forceps. I teased those saw tooth edges back into place and instilled 1% atropine sol. to dilate the pupil and help hold the edges in place by pressure. After a few minutes, I flushed the eye with mercurochrome 2% sol. and applied a tight well strapped bandage with instructions to sleep on his left side. This treatment was continued for several weeks till finally, the wounds healed. The rough edges smoothed down and the eye looked good.

His vision in the right eye was twenty-fiftieths, a plus fifty sphere combined with a plus fifty cylinder axis 180 gave him 20/30.

Vision in the left eye was twenty-fortieths, a plus fifty sphere gave him 20/30. A plus 1.50 sphere added to both eyes for near, gave him Jaeger 1.00 M

No. 3 soft lite lenses in good strong frames. He went back to his old job of filing piano plates with a new file. The State Industrial Commission allowed him $2,800 compensation.

NOTES on Medical Statistics

COLDS

Considering the population of U.S., there are about 300,000,000 colds yearly. The duration of a simple cold is approximately 5 days, which means that the people in this country have 1,500,000,000 days of colds with disability or, at least, inefficiency. More or less 40% of all days lost from work is due to common colds. This would mean that one working day each year is lost for each employee due to colds. Consequently, more than 60,000,000 days would be lost from work due to common cold. At an average of $7. per day the loss in earnings would amount to $420,000,000. Above that, each family in U.S. spends on the average $10. per year for medical attention and medicine for colds which again amounts to $400,000,000. The loss of the employer's production due to absenteeism for common cold is hard to evaluate. Yet, it was estimated that "the common cold is costing the American public well over one billion dollars per annum".

CASE PRESENTATIONS

This case is presented without comments.

A male patient who was first reported on in February 1945, at the age of 42. The family history was essentially negative with the exception that one brother had died at age 25, probably of pernicious anemia. The medical history of the patient was noncontributory. He was 6 ft. tall and weighed 185 lbs. There were no pathological findings of any kind at the time of this check up. In 1949 the patient was seen by another physician. He now stated that he had had scarlet fever in childhood followed by rheumatic fever, with 2 recurrences. Yet, he had passed the army examination; he was inducted and discharged because of color blindness. His present complaints were anorexia, nausea, weight loss, exhaustion, dyspnea, icterus and clay colored stools. Patient had been constipated and used laxatives and enemas. In September, 1948, patient was hospitalized, and a diagnosis of auricular fibrillation and heart enlargement was made. A G.I. series did not reveal any pathology. Patient was given digitoxin, which however worsened the nausea. A reexamination, in December 1948, again confirmed auricular fibrillation; a systolic and diastolic murmur at the apex was heard. The liver was not enlarged, but patient complained of tenderness in epigastrium on deep pressure. The icterus persisted. The icterus index was 26, cephalin flocculation, 3 plus. The sedimentation rate was 15/hour (Westergreen). Urine was dark, showed presence of bile; urobilinogen was faintly positive. Patient followed the advice to discontinue digitoxin; the nausea subsided, the stool resumed normal color, laxatives were not longer necessary, and patient gained weight. Then, the attending physician made a diagnosis of rheumatic endocarditis with mitral stenosis and insufficiency, yet was unable to explain the recurrent icterus, temporary acholic stools and occasional pain in left flank. First admission to another hospital in January, 1949. He complained of pains in back, sides and epigrastric region, and now, for the first time, he stated that he was in a car wreck in the summer of 1945 and that the pains may be sequels of that accident. He displayed severe dyspnea. He contended to have lost 32 lbs. since the summer of 1949; yet, with 155 lbs. he was not underweight. Pulse, 88; blood pressure, 112/60, temperature 97. Heart: sounds rather faint: apex pulsation generalized over apex, irregularity of heart beat with fibrillations. Liver: enlarged 2 inches below coastal margin. Lungs: no pathology. The skin is jaundiced, the conjunctivae also show icteric coloration. Urine: faint trace of albumin; bile present. No cells or casts. Blood: hemoglobin, 100% RBC/mm^3, 5,200,000; WBC/mm^3, 6,800; differential count, normal. Van den Bergh reaction (direct), positive in ½ min.; thymol turbidity, 15 units; cephalin flocculation, 3 plus. Kahn, negative. Stool, positive for bile, negative for occult blood. BMR, plus 9%. X-ray of intestinal tract and gallbladder, negative. Diagnosis: Auricular fibrillation, hepatitis. Second admission to the same hospital in November 1950. Patient complained of coughing spells of a few days duration with 'vomiting' of blood, which happened about every hour. Had 2 fainting

spells in past 3 weeks. Pulse 90. Blood pressure 110/70; temperature 97. Heart somewhat enlarged with frequent extrastystoles. Liver enlarged, not tender. There was no hemoptysis observed at bed rest. Sputum smear was negative; x-ray of lungs showed no signs of tuberculosis, yet interstitial fibrosis and possibility of bronchiectasis. The heart shadow is enlarged with a prominent pulmonary conus and small aorta. Cephalin flocculation, 4 plus in 24 hours. Urine, negative. Blood: hemoglobin 13 grams (80%); 4-1 million RBC; 11,000 WBC; Differential count, normal. Diagnosis: congenital heart disease (sic!); interstitial pulmonary fibrosis, secondary anemia due to recurrent hemoptysis. Third admission to the same hospital in December, 1950. Recurrent pulmonary hemorrhage. Pulmonary hemorrhage could not be controlled and patient expired the same day.

Autopsy report: right lung shows edema and congestion of the lower half of the lower lobe; the lower lobe of the left lung is involved in a soft, red, hemorrhagic, edematous process with all bronchial branches filled with clotted blood. Heart is enlarged with considerable free fluid in the pericardial sac. The mitral valve is thickened and calcified. In the left ventricle is a moderately fresh mural thrombus. The aortic valve is thickened and partially calcified. The left auricle shows petechial hemorrhages. The liver is grey, smaller than normal fibrotic and dense. Spleen, normal. Stomach is dilated and contains a large amount of blood, but no ulcerations or tumors. Adrenals, normal. Kidneys, slightly granular and gritty. Microscopical findings: heart reveals many areas of fibrosis and degeneration of amany myocardial fibers. Liver reveals rather marked lymphocytic infiltration and fibrosis. Lungs: marked congestion with red blood cells free within the alveolar spaces. Hilar lymph nodes show edema and mixed inflammatory infiltration. Pathologic diagnosis: chron hepatitis (cirrhosis) of liver with pulmonary infarcts; mural thrombi of heart; myocardial fibrosis; chronic lymphaedenitis. Final clinical diagnosis: rheumatic heart disease; auricular fibrillation; acute pulmonary edema and hemorrhage; hepatic cirrhosis.

(lit.: M. Oppenheim. Myocardosis Associated with Cirrhosis of the Liver. Schweiz. med. Wchnschr. 80: 795, July 29, 1950)

Cryptorchidism

In the family which I have attended to for many years are two brothers, now 18 and 20 years of age. Both brothers are perfect male specimens; yet, both have undescended right testicles. The older brother, while employed outside of his home town in a large manufacturing plant, was advised by the plant physician to have the condition surgically corrected, as in later years the undescended testicle may become malignant. The younger brother consulted me whether he, too, should submit to an operation. Which is the chance that an undescended testicle may undergo a cancerous change? M.D., South Carolina

Answer. Cryptorchidism is a relatively rare occurrence. W. W. Johnson reported that the incidence rate

was 17 per 1,000 in a survey of 31,608 young males between the ages 7 and 17. F. Hinamn and F. H. Benteen reviewed 40,000 hospital patients and found that malignant neoplasm of the testis occurred 20 times more frequently in undescended than in descended testicles. H. E. Campbell made a survey of 1,000 cases and stated that the cancer probability is 5 per cent when the testis remains in the abdomen and 1.2 percent when it remains in the inguinal canal. As to the patient's question whether or not surgical intervention would be advisable, we refer to the viewpoint of J. H. Kiefer. He stressed that an undescended testicle is more likely subject to carcinoma than a normally descended testicle. However, he voices the opinion that not the cryptorchidism in itself is the causative factor for a malignant development but that an inadequency of the testicle tissue is the real reason for a cancerous change in the form of an embryonal malignant neoplasm. Kiefer emphasizes that any hypoplastic undescended testicle should be surgically removed; yet, a testicle of normal or slightly subnormal size could be left exceptionally—when the patients objects to operation—in the inguinal canal. The patient should be checked, however, periodically so that any increase of size could be detected early.
(lit.: W. W. Johnson. J.A.M.A. 113:35, 1939; F. Hinman and F. H. Benteen. J. Urol. 35:378, 1936; H. E. Campbell, Arch. Surg. 44:353, 1942; J. H. Kiefer, Illinois Med. J. 91:297, June 1947)

SIDE GLANCES at History of Medicine

ENDOMETRIOSIS

The clinical entity of endometriosis was established by F. D. von Recklinghausen (Die Adenomyome und Cystadenome des Uterus und der Tubenwandung; ihre Abkunft von Resten des Wolff'schen Koerpers. Im Anhang: 'Klinische Notizen zu den voluminoesen Adenomyomen des Uterus; by W. A. Freund. Berlin. W. Hirschwald, 1896, p. 247). The publication of J. A. Sampson: "Perforating hemorrhagic (chocolate) cysts of the ovary: their importance and especially their relation to pelvic adenomas of the endometrial type ('adenomyoma' of the uterus, retrovaginal septum, sigmoid, etc.)", Arch. Surg., 3:245, Sept., 1921, brought final recognition of the condition and its diagnosis; in the same year, endometriosis of the bladder was described for the first time, by E. Starr Judd (Andenomyoma presenting as a tumor of the bladder. S. Clin. North America, 1:1271, Oct. 1921).

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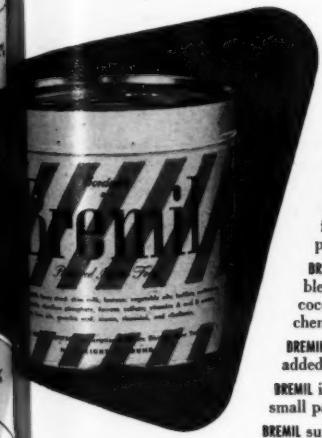

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1. Gardner, L. I.; MacLachlan, E. A.; Pick, W.; Terry, M. L., and Butler, A. M.: *Pediatrics* 5:228, 1950.
2. Nesbit, H. T.: *Texas State J. M.* 38:551, 1943.
3. May, C. D., et al.: *Bull. Univ. Minnesota Hospitals* 21:208, 1950.
4. Block, R. J.: *J. Am. Dietetic Assn.* 25:937, 1949.

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DIAGNOSTIC SUGGESTIONS

Exophthalmus (thyroid)

It should be differentiated between thyrotoxic exophthalmus (found in exophthalmic goiter in young adults. It is 3 to 4 times more common in women than in men. There is a neuromuscular degeneration of the extraocular muscles. The proptosis is more apparent than real. The re is true lid retraction due to sympathetic stimulation) and thyrotropic exophthalmus (appears later in life, is 3 to 4 times more common in men than in women, and is of pituitary origin. There is no re;ation to sympathetic activity. The BMR may be subnormal while it is always increased in the first form. There is pathological enlargement of the extraocular muscles (fibrosis, edema, round cell infiltration, degeneration). Retrobulbar tension is hard). (C. D. Townes. The J. of the Kentucky State Med. Ass. 5:208, May, 1950).

Trigger Finger

Trigger finger is generally due to the formation of nodules in the tendon sheath. The patients complain of the tender nodule, pain in grasping objects, impairment of all manipulations by sudden arrest of the finger in flexion or extension so that the intended movement could only be continued by passive support. The level of the metacarpophalangeal articulation at the volar surface was involved in all cases. On pressure this localization seems to be particularly disposed for the formation of a nodule which decreases the gliding of the tendon in movements. Most of the cases indicated repeated pressure of a tool or another object on the palm of the hand as the cause. (W. Focke. Langenbeck's Arch. f. klin. Chir. u. Deuthsche Zeitcshr f. Chir. 266:74, Aug. 12, 1950)

Mediastinal and Subcutaneous Emphysema

"The aspiration of a foreign body into the respiratory tract is one of the many conditions (others: bronchial asthma, parturition, bronchitis, intratacheal anesthesia and so forth) causing an increase in the intrapulmonary pressure leading to mediastinal and subcutaneous emphysema." The alveoli become distented; air passes from them to the interstitial pulmonary tissue, the tiny air bubbles coalesce and move along the perivascular spaces toward the mediastinum; from here the air goes either along the great vessels into the neck or through weak spots of the mediastinum into the intrapleural spaces (pneumothorax) or along the periesophageal areolar tissue into the retroperitoneal region. "It may extend out through the inguinal rings and into the subcutaneous tissues of the thighs and lower part of the abdominal wall. Therefore, following aspiration of a foreign body, air in the subcutaneous tissues is an external indication that mediastinal emphysema is present and should be a warning that more serious complications, such as pneumothorax or compression of the great veins, may develop." (H. M. Purcell; S. D. Mills and H. W Schmidt. Proc. Staff. Meet., Mayo Clinic 25:678, Dec 6, 1950).

Syphilitic Aortitis

Author observed 20 cases and reviewed 200 x-ray pictures; he came to the conclusion that the demonstration of calcification of the ascending aorta roentgenologically may be considered as a reliable pathognomic sign of syphilitic aortitis (J. Jackman. Pennsylv. Med. J. 53:972, September 1950)

DIAGNOSTIC SUGGESTIONS

Essential Hyperlipemia

Hyperlipemia denotes abnormal increase in the neutral fat of the serum; this may be found in association with diabetes mellitus, lipid nephrosis, pancreatitis, hepatic disease, poisoning, pregnancy, leukemias, etc., but it also may be a disorder of fat metabolism of undetermined origin, characterized by hyperlipemia (serum has milky or creamy appearance); it may be asymptomatic or accompanied with abdominal pain, eruptive xanthomatosis, lipemic retinitis and hepatosplenomegaly. With the patient on low fat diet, the syndrome may disappear only to reappear with resumption of an average diet. In some cases the prominent symptom is abdominal pain, culminating in abdominal crises and simulating the picture of 'surgical abdomen' (such as in tabetic crises, lead colic, allergies, black widow bite, acute porphyria and periarteritis nodosa). Authors stress that this disorder may be more frequent than reported in the literature and it should be kept in mind in every instance of abdominal pain of obscure origin to avoid unneccessary laparotomies. (E. R. Movitt; B. Gerstl; F. Sherwood and C. C. Epstein Arch. Int. Med. 1:79, January 1951)

Alcoholism

Author classifies chronic alcoholics into four groups: 1) Habitual drinkers with daily and continuous craving for liquor; 2) weekly drinkers who drink to excess 1 or more days every week and who consume quantities of liquor which depend on situational factors; 3) periodic drinkers who abstain completely from drinking for considerable intervals and who indulge in drinking sprees lasting for days or weeks; 4) accidental drinkers who are generally abstinent but who on special (social) occasions drink to excess and lose self-control. Author found in more than 50 percent of his patients mild emotional tension, only in 15 percent psychopathic traits and only in 3 percent intermittent mental disturbances. This distribution, according to the author, does not differ from that of the daily clientele of a general practitioner. The author thinks that alcoholism is caused by a 'low alcohol lime' which means that after intake of relatively small amounts of liquor an irresistable craving for more liquor ensues. He contends that the level of the limen is constitutional, and that persons with a low limen should be entirely abstinent. (O. Maretensen-Larsen. Brit. J. Addiction, 47:43, January 1950)

Hemochromatosis (Bronze-Diabetes)

This syndrome is characterized by the triad:hepatomegaly, diabetes mellitus and bronzing of the skin. The disease is caused by absorption of excessive amounts of iron with deposition of iron pigments in various organs (particularly, liver, spleen, pancreas, atriate muscles and skin). with resultant progressive cirrhosis. There are three clinicopathological variants: 1) idiopathic, 2) dietary (as proved by experiments with rats fed on low phosphate, high iron diet), 3) transusion. The diagnosis may be confirmed by a reliable laboratory test: serum iron and iron binding capacity. (Wm. A. Wolfe; J. H. Crampton. Bull. of the Mason Clinic, 4:119, December 1950).

DIAGNOSTIC SUGGESTIONS

Electrolyte Metabolism

An Outline of the Disorders of Electrolyte Metabolism. I. Disturbances of the water balance. A. Dehydration. 1. water deprivation; 2. electrolyte loss. B. Overhydration. 1. retention of electroyltes; 2. water intoxication. II. Disturbances of acid-base balance. A. Alkalosis. 1. metabolic; 2. rescpiratory. B. Acidosis 1. metabolic; b. respiratory.

When a disturbance results in a tendency toward decreased pH, it is called acidosis, whereas if the pH increases, it is called alkalosis. When the disturbance of the acid-base balance results from changes in pulmonary ventilation, it is a respiratory acidosis or alkalosis, whereas when loss of body fluids are responsible or administration of acid or alkaline substances or altered renal function, it is a metabolic acidosis or alkalosis. Dehydration from deprivation of water: minimal loss of electrolytyes; hypertonic extracellular fluid with decreased volume; symptoms, thirst, dry skin, restlessness, full pulse, normal blood pressure, concentrated urine. Dehydration from loss of electrolytes: low concentration of sodium and chloride; symtoms, weakness, pallor, low blood pressure, dilute urine (occurs in diabetic acidosis, addisonian crises, heat exhaustion, diarrhea, vomiting, gastro-intestinal fistulas). Over hydration with retention of sodium: large volume of extracellular fluid. Edema is frequent (heart failure, nephritis, intake of excessive amounts of sodium chloride). Overhydration caused by intake of large amounts of water "water intoxication." No edema, yet hypotonicity. In milder degrees: nervousness, salivation, vomiting; in severe degree: disorientation, stupor, irregular twitching movements of extremities, convulsions. In most varieties of acidosis, e.g. diabetic acidosis, the carbon dioxide combining power of the plasma is decreased. A less familiar variety is seen when pulmonary factors prevent free excretion of carbon dioxide (emphysema) thereby increasing the acidity of body fluids. In alkalosis such as seen in pyloric stenosis, the plasma carbon dioxide combining power increases; yet when there is an accelerated loss of carbon dioxide (chronic hyperventilation caused by encephalitis or salicylate intoxication), alkalosis is associated with decreased carbon dioxide power. (C. F. Gastineau. Proc. Staff Meet., Mayo Clinic, 23: 630, Nov. 8, 1950)

Anuria

Three types: 1) prerenal anuria due to lowering of blood pressure to levels inadequate for glomerular filtration (shock, hemorrhage, dehydration, heart failure); 2) renal anuria due to inhibition of urine secretion (lower nephron nephrosis, tubular poisons); 3) postrenal anuria due to obstruction of urine flow below renal pelvis. Treatment: I. remove cause; restore blood volume, blood pressure and hemoglobin by blood transfusion. Cystoscopy and catherization of both ureters; if obstruction present, nephrostomy may be necessary. Blood sodium, chloride, bicarbonate and urea should be determined. II. Limit fluid intake, prescribe low-protein, high-carbohydrate diet; employ dialysis if edema is generalized or if the blood urea value exceeds 200 mgm per cent. III. Replacement of fluid and salt excreted. (A. Miller. Proc. Roy. Soc. Med. 42:801, 1949).

DIAGNOSTIC SUGGESTIONS

Manic-Depressive Psychosis

All the symptoms of manic-depressive psychosis, depressive type, may be classified as autonomic, emotional or mental. Autonomic disturbances include hot flushes, tachycardia, dyspnea and weakness, occipitocervical pains, coldness and numbness of hands and feet, dizziness or a woozey feeling in the head, marked fatigue or psychomotor retardation, pain or distress in the head, stomach or chest, and many others. Physical complaints of this kind are often emphasized by the patient, and physical rather than psychiatric treatment sought. Patients will often deny depression, only to admit later to emotional symptoms such as low spirits, anxiety, sensitiveness, insomnia, feelings of guilt, remorse, unreality or impending insanity. Mental symptoms include psychomotor retardation, impaired concentration and memory, suspiciousness, ideas of guilt and unworthiness, morbid thoughts, lack of interest in usual pursuits, preoccupation with religion, illusions and misinterpretations, and others. Any patient with a cycloid personality who consults a physician and has two or three symptoms in each of these groups should be suspected of being in a depressive phase of manic-depressive psychosis. The depressive patient differs from the neurotic in being ashamed of his illness and blaming himself for it, while the neurotic may use his symptoms to advantage and blames them on others. The depression and guilt of the depressive person are endogenous, while those of the neurotic are transitory and related to the environment. (John D. Campbell. J. Nerv. & Ment. Dis. 112:206, September 1950)

Gall Bladder Disease

Three types may be distinguished: 1) colic—good digestion between attacks; 2) colic associated with dyspepsia; 3) chronic indigestion—no colic. Physical examination generally gives no clear picture. As a rule the gallbladder is not palpable. If nothing definite is shown in the x-ray films, duodenal drainage (abnormal concentration of bile) may reveal some information (R. S. Sanders, Journ. of the Iowa State Med. Soc. 40:435, Sept. 1950)

Xanthelasma

Xanthelasma, a lipoid infiltration of the eyelids, ordinarily is considered a benign lesion. Montgomery states that 20 percent of these have lipoid infitration of the coronary arteries. An increase in blood lipoids may be present indicating systemic disease. (T. L. Shields. J. Ins. Med. 4:18, Sept.-Oct.-Nov., 1950). Xanthelasma is also sometimes associated with hepatic disorders (F. Urbach. Skin Diseases, Nutrition and Metabolism. Grune and Stratton, N.Y. 1946)

Kleine-Levin Syndrone

This is a relatively rare symptom-complex consisting of periodic attacks of abnormal sleep lasting several days (hypersomnia) and excessive hunger during these attacks (bulimia); hypermotility, irritability and mild mental confusion may also be present. It has been suggested that pathophysiological processes affecting the hypothalamus are etiologically responsible. (H. Palmer. New Zealand M.J. 49:28, Febr. 1950. J. Ronald. Brit. M.J. 2:326, Sept. 7, 1946)

DIAGNOSTIC SUGGESTIONS

Intraocular Pressure

Description of a relatively simple method to test chronic glaucoma. The method can be used both at the office and the hospital. The necessary instruments are: a Schiotz tonometer, a sphygmomanometer and ice water in a basin. The blood pressure cuff is fastened around the neck in a way to compress both jugular veins simultaneously. After measuring the tension of each eye, the patient's hand is placed in the ice water and the rubber cuff is inflated. The pressure should be maintained between 50 and 60 mm. mercury. After one minute, the eye tension is measured again, then the hand taken out of the water and the cuff loosened. If the eye tension has increased more han 9mm. the intraocular pressure is abnormal and the diagnosis of chronic simple glaucoma is probable; when the second reading shows a rise over 30 mm, the diagnosis is more certain, irrespective of the primary increase of tension. This test was positive in 91% of unoperated eyes with chronic simple glaucoma. Eyes with recurrent acute congestive glaucoma do not show a positive test in latent periods. *(S. Bloomfield. New York State J. Med. 49:659, 1949)*

Xanthoma Diabeticorum

This paper is interesting for the general practitioner because of the description of some unusual signs which might point to the presence of a hitherto undiagnosed diabetes mellitus. "Xanthomatous eruptions in diabetics are uncommon . . . the dissemination of the lesions in xanthoma diabeticorum is probably caused by damage to the reticuloendothelial system. The lesions usually appear suddenly and favor the extensor surfaces, buttocks, palms and soles. In many cases their appearance first suggests the presence of diabetes. The lesions may be small, firm papules, nodules, plaques, or in rare cases keloid-like linear lesions. During the eruptive phase itching is usually intense. The color is characteristic with an inflammatory element which is absent in other types of xanthoma. Reddish with yellowish, or chamois-colored centers; the nodular lesions may stimulate pustules. . . . The blood cholesterol, fatty acids and neural fats are greatly increased. In cases without pancreatic involvement, the lesions respond to dietetic control and insulin, but recurrences are common. . . ." (R. F. Morton. The J. of the Missouri State Med. Ass., 11:838, November 1950).

SIDE GLANCES at History of Medicine

ISLANDS OF LANGERHANS

Langerhans' islets in the pancreas were first described by P. Langerhans (Beitraege zur mikroskopischen Anatomie der Bauchspeicheldruese. Berlin. W. Schade, 1869). The term Langerhans islet cell was first employed by E. La Guesse (Comp. rend. Soc. de biol., 46:664, 1894). M. Gentes (Notes sur les terminations nerveuses d'ilôts de Langerhans du pancreas. Compt. rend. Soc. de bial., 54:212, 1902) first demonstrated that both myelinated and nonmyelinated nerve fibers supply the Langerhans islets.

DIAGNOSTIC SUGGESTIONS

Occupational Diseases: Mouth

The tack spitter's teeth (usually in the upholstery trade) — teeth become serrated so as to resemble a miniature hacksaw; glass blowers often have an evenly round hole involving the four front teeth, a little smaller than a dime. The bugler and cornetist often injure their lips and also the anterior surfaces of their front teeth. Button workers have often eroded teeth, particularly the molars. Explosive gingivitis, with or without hemorrhage, in an industrial worker should be a warning sign: mercury poisoning is associated with stomatitis, salivation, metallic odors and denuded teeth. Trichloroethylene affects the trigeminal nerve with predilection. In rare cases, atrophy of the fifth nerve after exposure occurs with necrosis of some or all teeth. Lead line of gums is universally known. Bismuth may cause a similar line. Many industrial chemicals modify taste by olfactorial damage: arsenic, zinc sulfate, acids. Caries of teeth in bakers and confectioners has been reported from Belgium and Germany. (C. P. McCord. Indust. Med. and Surg. 8:387, August, 1950).

Appendicitis

The rather high incidence of rupture of appendix and peritonitis due to appendicitis in children is due to 1) appendicitis may not be recognized in time, as infants and small children are unable to give a description of their symptoms; 2) the appendix of children contains much lymphoid tissue which offers little resistance; 3) the omentum is poorly developed and offers no protection. (W. M. Riker. Quart. Bull., Northwestern Med. School, 24:49, 1950).

Infertility in the Male

The following impairments have been found to be responsible for male infertility in the majority of cases: mumps orchitis, endocrine disturbances (such as untreated Froehlich's syndrome), mechanical block (bilateral gonorrheal epididymitis), congenital defects (atresia of vas deferens, epididymal detachment); author contends that childless marriages are to about 75 per cent due to male infertility. (Wm. F. Melick. The J. of the Missouri State M. Ass. 9:663, Sept. 1950).

Uretral Obstructions in the Female

Causes may be cystocele with prolapse of uterus; inflammatory processes in the pelvis; fibroma of the uterus; adenocarcinoma of the uterine fundus; carcinoma of the cervix uteri; ovarian tumors, both benign and malignant. The mechanisms of ureteral obstruction differ according to the etilogic factors: in inflammatory pelvic processes the ureter may be involved by outside pressure or by extension of the infection into the ureter (atony or stricture); uterus prolapse may cause twisting, kinking, overstretching or displacing of the ureter; carcinoma of the uterine cervix may either compress the ureter or grow into the tissue. X-ray treatment of cervical cancer also may result in obstruction of the ureter by edema, inflammatory reaction or constrictive fibrosis. As a consequence of ureteral obstruction severe hydronephrosis may develop which may lead in some cases to grave involvement of the renal structure. (J. P. Long and J. B. Montgomery. Am. J. Obst. & Gynec. 59:552, 1950).

DIAGNOSTIC SUGGESTIONS

Breathing

1) Tachypnea, rapid breathing, generally observed in states of fear and passion; 2)bradypnea, slow breathing, following depressing amounts of sedatives and accompanying increased intracranial pressure; 3) hyperpnea, increased depth of breathing, after strenuous exercise; 4) hypopnea, reduced depth of breathing, in sleep, poor posture, spondylitis rhizomelique, emphysema, paretic respiratory muscles; 5) periodic breathing, a) Cheyne-Stokes breathing, unvoluntary arythmia in which a period of apnea (or oligopnea) is followed by a series of ventiliations in which each successive tidal volume is increased and the rate simultaneously quickens, until dyspnea may be present, leading again to a period of apnea (in severe heart failure; in normal persons at high altitudes before adaptation); b) Biot's breathing, periods of tachypnea and hypopnea alternate with apnea (occasionally in meningitis, encephalitis, heat stroke, brain abscess, head trauma); 6) quantitative arrhythmias: 1) dyspnea, difficult breathing; b) orthopnea, breathing must be performed in erect position (congestive heart failure). (Ed. Wm. A. Sodeman. Pathologic Physiology: Mechanisms of Disease. Philadelphia, W. B. Saunders Co. 1950. Chapter 6. J. H. Seabury. Pulmonary Ventilation and Respiration: Tests of Respiratory Function, pp. 215-217)

Friedreich's Ataxia

Cardiac involvement is a serious and relatively frequent concomitant of Friedreich's Ataxia. The authors found systolic murmurs in three siblings suffering from this hereditary type of sclerosis. Three possible explanations are given: 1) the murmur is functional and accidental; 2) it is caused by rheumatic heart disease; 3) it is due to an auricular septal defect, possibly also a patent foramen ovale. French investigators pointed to arrhythmias encountered in Friedreich's Ataxia; they considered them as a cardiobulbar syndrome or a congenital defect of the myocardium. Both hypothesis are unproved. (T. H. Lorenz; C. M. Kurz and H. H. Shapiro. Arch. Int. Med. 2:412, September, 1950).

NOTES on Medical Statistics

DYSMENORRHREA

The following estimates have been made for the incidence of dysmenorrhrea: more than 50% of all menstruating women; 35% of all adult women; 48% of 302 College girls; 50% of 14,264 University women; 2.8% of 4,500 consecutive patients with gynecological disturbances (Virg. Med. Monthly, 69:19,1942)

THERAPEUTIC SUGGESTIONS

Heart Arrhythmia and Parenteral Quinidine

Quinidine lactate (0.65 Gm) administered intramuscularly is no more toxic than quinidine given orally in similar doses. A maximal-cardiac effect in subjects with regular sinus rhythm (normal and abnormal hearts) is attained in about 30 minutes. The duration of the maximal effect lasts between 2 and 4 hours in subjects with normal hearts and at least 6 hours in those with abnormal hearts. Ar 24 hours a small but significant quinidine effect persists. Of 22 individuals with heart arrhythmias 15 were restored to regular sinus rhythm by single or multiple parenteral administrations of quinidine. The Maximal effect as estimated by slowing of the ectopic pace maker occurs between 30 and 60 minutes following intramusclar administration. When rapid therapeutic effect is important, hourly administration is indicated; when necessity for speed in therapeutic response is less urgent, administration should be at intervals of 3 to 4 hours. (H. Binder; J. Burstein; Wm. Horowitz; E. Gersh and R. Smelin. Arch. Int. Med. 6:917, December, 1950).

Cardiac Pain

"An extremely interesting and provocative approach to therapy of somatic aspects of cardiac pain has been developed recently. . . . The studies include the uncovering of the presence of zones of hypersensitivity or trigger areas in the skeletal muscle. The trigger areas are in myofascial structures and produce a specific and characteristic reference of pain on pressure stimulation or needling. This pattern of reference is the same regardless of the activating cause of the trigger mechanism. The muscles incolved in this phenomenon in coronary disease are the pectoralis major and minor and the serratus anterior. It is essential that careful palapation of muscles is carried out to ascertain the precise location of these trigger areas. The technique consists of infiltrating the hyperalgesia zones with a few cubic centimeters of 0.25 percent or 0.5 percent of procaine or spraying the area with ethyl chloride, Best results are obtained in patients whose painful syndromes referred to somatic structures were precipitated by myocardial infarction. (E. M. Papper. Pennsylvania Med. J. 53:801, August 1950).

Tuberculosis

Authors report on a 12 months observation of 541 patients with pulmonary tuberculosis; streptomycin was added to other therapeutic measures in half of the group; the other half served as controls. Greater improvement occurred among patients who received streptomycin in addition to other forms of therapy. The differences between the two groups were very marked with respect to both the time factor and extent. By the end of 3 months, improvement had occurred in a much larger proportion of the streptomycin group than of the controls. The more favorable position of the streptomycin treated cases was evident for all factors compared such as temperature, body weight, bacteriological findings, amount of sputum and roentgenological change. (E. R. Long and S. H. Ferbee. Publ. Health Rep. 14:1421, Nov. 3, 1950).

THERAPEUTIC SUGGESTIONS

Undecylenic Acid in Skin Diseases

Favorable results were reported by oral administration of undecylenic acid in psoriasis and neurodermatitis (H. H. Perman. J.A.M.A. 139:444, Feb., 12 1949; H. H. Perlman and I. L. Milberg. ibid. 140:865, July, 9, 1949). Less convincing results were reported by other authors: of 25 cases of psoriasis, 4 milder cases showed 100 percent clearing and 6 showed 50 percent or more improvement; of 18 cases neurodermatitis, only 3 were freed from itching and 75 percent of the lesions disappeared. The drug was started with 0.5 Gm. after each meal and was increased to 14 Gms. (R. Q. Crotty, J. Invest. Dermat. 14:313, May, 1950)—Undecylenic acid alone or in combination with lipids in psoriasis and neurodermatitis caused a satisfactory response in 40 percent of cases (H. Goodman. The Merck Report, 1:19, Jan., 1950). Various side reactions have been reported: exfoliative dermatitis (T. Behrman. J.A.M.A. 141:407, Oct. 8, 1950—B. L. Schiff. ibid 8:620, Oct. 21, 1950); nausea and vomiting (R. Q. Crotty, l.c.); erythema and exudative dermatitis (L. M. Nelson J. Invest. Dermat. 14:75, 1950).

Fracture of Clavicle in Adults

Decision must be made for any given clavicular fracture whether a simple restrictive figure-of-eight splint or whether immobilization of the bone by external or internal fixation is indicated. "When nonoperative management is chosen the use of an ordinary broomstick is helpful. A table is placed with one end against a wall, and the patient sits with his back to the wall and with a piece of plank, 1.9 cm. thick, beneath the buttocks. The broomstick is laid between the wall and the edges of the plank at the angle of 45°. A felt pad is placed against the dorsal spine and the patient lies with the vertebral column against the broomstick and the arms hanging on either side of the table". The fracture site may be infiltrated with novocain. Reduction of the faces of transverse fractures can often be accomplished by seizing the fragments through the skin with towel clips. After padding, plaster bandage is applied over each shoulder crossing the broomstick; it should be compressed against the thorax rather than into the axilla (radial nerve paralysis!). Before setting has occurred, the broomstick is withdrawn and replaced outside the plaster. Patient remains lying against the broomstick until the splint has hardened.—Open reduction should be reserved for the rare cases in which damage to blood vessels and nerves is imminent. (T. B. Quigley. New England J. Med. 243:286, Aug. 24, 1950).

Motion Sickness

Scopolamine (hyoscine) hydrobromide, diphenhydramine (Benadryl) hydrochloride, dramamine, trihexyphenidyl (artone) and chlorocyclizine (perazil) hydrochloride were all notably effective in decreasing the incidence of seasickness of normal, unselected soldiers. Among persons known to be susceptible to motion sickness, phenindamine tartrate showed a slight protective action, but was less beneficial than scopolamine, dramamine or benadryl. The latter two drugs were tested therapeutically and were found only insignificantly effective. Side effects noted were: blurred vision and dryness of mouth. (H. I. Chaim; W. J. Noell and P. K. Smith. Arch. Int. Med. 6:810, December, 1950).

THERAPEUTIC SUGGESTIONS

Penicillin Prophylaxis

"Fifty-Seven cases of subacute and 20 cases of acute bacterial endocarditis following operative, diagnostic instrumental, and manipulative procedures are described in patients ranging from 14 to 86 years of age A vast variety of manipulations and diseases which injure mucous membrane and facilitate the entrance of bacteria into the blood stream may lead to bacterial endocarditis in the presence of valvular disease. These include infections and operations in the ear, nose and throat; tooth extraction; bronchoscopy; genitourinary infections, operations, and diagnostic procedures; . . . Such minor conditions as cold, prostatic massage, enteritis, and toe infection have preceded bacterial endocarditis." Since valvular lesions are very common in persons over 50, although often not obvious clinically, penicillin prophylaxis (300,000 units before dental operation — children 150,000 units — and the same dosis one half hour after operation, and additional 300,000 units 12-18 hours thereafter. In major operation, 300,000 units should be given at the operating table or if necessary, a more prolonged prophylactic penicillin treatment might be advisable) prior to operation or diagnostic or manipulative procedures may be instituted. (P. A. Lichtman and A. M. Master. Med. Ann. Distr. of Columb. 12:662 Dec. 1950)

Parkinsonism

Lyvisane (N- (2-diethylamino-n-propyl) phenothaizine hydrochloride) was administered to 16 patients. The drug is supplied in 0.05 g. tablets. Within one week the patients were adjusted to their individual effective dose which varied from 4 to 10 tablets daily. As the drug has toxic side-effects, a higher dose should not be administered unless more clinical experiences has been secured. Results: complete alleviation in 1; good results in 10; improved 4; no improvement in 1. Rigidity responds better than tremor. Toxic effects: drowsiness, lassitude, vertigo (counteracted by amphetamine sulfate); formication, irritation, cramps; rarely, dryness of mouth, transient diplopia and vasomotor reactions. (H. Palmer and D. J. A. Gallagher. Brit. M.J. 2:558, Sept. 2, 1950).

Backache

The described treatment is indicated in cases with well localized pain in muscular areas. If a trigger point (definitely sensitive to pressure) cannot be located, the treatment will be of no avail. Indications are: soft tissue pains without x-ray findings, going under the names of lumbago, sacroiliac and sacrolumbar sprains. The treatment consists of injecting a solution: procaine base 0.075 Gm; propyl aminobenzoate 0.30 mg; and benzyl alcohol, 0.025 Gm., in a vehicle of sesame oil sufficient to make 5 cc. About 1,000 individual injections have been given over a period of 15 years. There have been no serious side effects. 80 percent of those treated during their first attack of soft tissue backache showed immediate response and remained free of symptoms. Those with a history of repeated attacks showed a similar response but about 30 percent relapsed within one year. Complete failures are due to inability to locate the trigger point at the first injection or to erroneous diagnosis.

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BOOK REVIEWS

An Outline of Urology

By C. D. Creevy, M.D. Director of the Division of Urology in the Department of Surgery of the Medical School University of Minnesota.
129 Pages. Paper. Burgess Publishing Company, Minneapolis, Minnesota. 1940. $3.75.

This book is intended for the medical student. It is written in a succinct style and the subjects are treated in a lucid and concise manner. The presentation starts out with the anatomy and physiology of the urinary system and the male genital organs. The chapter on symptoms and terminology is impressive. The sections on examinations of the genito-urinary system—physical, laboratory and roentgenological—contain everything important to know for the general practitioner. The main part of this work deals with diagnosis and treatment—medical and surgical—of pathological processes. This 'Outline of Urology' should be highly recommended as a standard textbook for the library of every general practitioner. He will use it, time and again, with great benefit as not only the text but also the many clear illustrations are very instructive. The bibliography is extensive, judiciously selected and helpful.

The Prostate Gland

By Herbert R. Kenyon. Asociate Clinical Professor, Department of Urology, New York University. Random House, N.Y., 1950. 194 pages. Cloth. $2.95.

The author's aim is essentially to give the laymen information on the importance of the prostate gland in health and disease. Yet, as the description reflects profound knowledge and experience, the reading will prove to be equally profitable for the professional man who wants to familiarize himself and his patients with the special problems of the pathology and the treatment of the prostate gland.

General Psychotherapy. Dynamics and Procedures

By D. Edwin Cameron. Grune and Stratton, New York, 1950. 304 pages. Cloth. $5.

Surveying this book of Dr. Cameron who is Professor of Psychiatry at McGill University regards its usefulness for the general practitioner, it should be stressed that this reviewer has hardly read any book on the subject of psychotherapy which would be of more benefit in general practice. While this work is written for the psychiatrist, it is explanatory and interpretative in a form which does not presuppose a special training. It outlines the indications and contraindications of psychotherapy; it emphasizes its potentialities and its limits. While it adheres to analytic techniques in integrative psychotherapy, it does not so in a sectarian way; and the author does not accept all parts of the psycho-analytic dogma as incontestable. He also recognizes the value of direct psychotherapy in its various ramifications: discussion, explanation, reassurance, suggestion, hypnosis, re-education and conditioning. In certain cases he recommends the use of adjuvants such as disinhibiting drugs (sodium amytal, pentothal, nitrous oxide, ether, insulin, etc.) and also the application of electro-shock. Group therapy, nursing therapy; and social psychotherapy are enlarged upon as appropriate methods of approach. The exposition of psychodynamics is clear and well formulated, and will prove exceedingly helpful for the general practitioner in understanding his patient's symptoms; the chapter on the training of the psychotherapist will introduce the reader in his own difficulties in handling his patient psychotherapeutically. F.R.St.

BOOK REVIEWS

Physical Examination in Health and Diseases

By Rudolph H. Kampmeier, M.D. Philadelphia, F. E. Davis Company, 1950. Cloth. 821 pages. $1.08.

Dr. Kampmeier has written a very valuable and helpful book. As this book is prepared particularly for students it does not bring new material. However, the diagnostic methods in almost all branches of medicine are judiciously selected, concisely described and enriched by particularly instructive illustrations. Chapter II was written by Dr. William T. Orr on the diagnosis of nervous functions. To this reviewer this chapter did not appear as impressive as the presentations written by Dr. Kampmeier. This book can be recommended highly to every general practitioner.

BOOKS RECEIVED

CYBERNETICS. CIRCULAR CAUSAL AND FEED BACK MECHANISMS IN BIOLOGICAL AND SOCIAL SYSTEMS. Transactions of the Sixth Conference, March 24-25, 1949, New York. ed. by Heinz von Foerster. Josiah Macy, Jr., Foundation, 1950. 209 pages, paper.

ANTIHISTAMINES, INDUSTRY AND PRODUCT SURVEY.
By Nathan Wishnefsky, B.S., R.S. Aries & Associates. Chemonomics, Inc. Publ. 1950. 157 pages. paper. $5.

PRINCIPLES OF GENERAL PSYCHOPATHOLOGY.
By Siegfried Fisher, M.D. Philosophical Library, New York, 1950. 327 Pages. Cloth. $4.75.

VERNAL CONJUNCTIVITIS.
By N. N. Beigelman, M.D. University of Southern California Press. Los Angeles, Cal. 1950. 430 pages. Cloth. $6.

EYES AND INDUSTRY.
By Hedwig S. Kuhn, M.D. Second Edition. The C. V. Mosby Company, St. Louis, 1950. 378 pages. Cloth $8.50.

EMOTIONS AND MEMORY.
By David Rapaport, Ph.D. Second Edition International Universities Press, Inc. 1950, New York. 282 pages. Cloth. $4.

HYPNOSIS, THEORY, PRACTICE AND APPLICATION.
By Raphael H. Rhodes. The citadel Press, New York, 1950. 176 pages. Cloth. $3.

PRINCIPLES OF PERSONALITY COUNSELING.
By Frederic C. Thorne, M.D., Ph.D. Journal of Clinical Psychology. Brandon, Vermont. 491 pages. Cloth.

GROUP LIFE.
The Nature and Treatment of its specific Conflicts. By Marshall C. Greco. Philosophical Library, N. Y. 1950. 357 pages. Cloth. $4.75.

PRINCIPLES OF PSYCHODYNAMICS.
By edoardo Weiss, M.D. Grune & Stratton, N. Y., 1950. 268 pages. Cloth.

GENERAL PSYCHOTHERAPY, DYNAMICS AND PROCEDURES.
By D. Ewen Cameron, M.D. Grune & Stratton, N. Y., 1950. 302 pages. Cloth.

MEDICAL DISEASES OF THE KIDNEY.
By J. F. A. McManus, M.D. Lea & Febiger, Philadelphia. 1950. 176 pages. Cloth.

THE CEREBRAL CORTEX OF MAN.
A Clinical Study of Localization of Function. By Wilder Penfield C.M.S., M.D. and Theodore Rasmussen, M.D. The Macmillan Company, New York, 1950. 248 pages. Cloth. $6.50.

PRACTICAL EMULSIONS.
By H. Bennett. Chemical Publishing Company, Inc. Brooklyn, N. Y. 1947. 583 pages. Cloth. $3.75.

WHEN MINDS GO WRONG
By John Maurice Grimes, M.D., *Twenty years a psychiatrist, Four Years a staff-member of the Council on Medical Education and Hospitals of the American Medical Association, Author of "Institutional Care of Mental Patients in the United States"*, John Maurice Grimes, M.D., 1950, $5.00.

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